Title 48
PUBLIC HEALTHCGENERAL
Part I. General Administration
Subpart 5. Health Planning

Chapter 125. Facility Need Review

§12501. Introduction

A. General Information

1. The Department of Health and Hospitals will conduct a Facility Need Review (FNR) for nursing facility (NF) beds, including skilled nursing facility (SNF) beds, and Intermediate Care Facility beds for the Mentally Retarded (ICF-MR), to determine if there is a need for additional beds to enroll in the Title XIX Program.

2. CFR 42 Part 442.12(d) allows the Medicaid agency to refuse to execute a provider agreement if adequate documentation showing good cause for such refusal has been compiled (i.e., when sufficient beds are available to serve the Title XIX population). The Facility Need Review Program will review applications for additional beds/facilities to determine whether good cause exists to deny participation in the Title XIX Program to prospective providers of Nursing Facility Services (Skilled, IC-I and IC-II), and ICF-MR services.

3. Applications are submitted to:

Department of Health and Hospitals
Bureau of Health Services Financing
Facility Need Review Program
P.O. Box 91030
Baton Rouge, LA 70821-9030
Telephone: (225) 342-3881

B. Definitions. When used in this rule the following terms and phrases shall have the following meanings unless the context requires otherwise:

Applicant- the person who is developing the proposal for purposes of enrolling the facility and/or beds in Medicaid. See definition of *Person*.

Applicant Representative- the person specified by the applicant on the application form to whom written notifications are sent relative to the status of the application during the review process.

Approval- a determination by the department that a proposal meets the criteria of the Facility Need Review Program for purposes of participating in Medicaid.

Approved- beds and/or facilities which are grandfathered in accordance with the grandfather provisions of this program and/or beds approved in accordance with the Facility Need Review Program.

Community Home- a type of community residential facility which has a capacity of eight or fewer beds.

Department- the Department of Health and Hospitals in the state of Louisiana.

Department of Health and Hospitals (DHH)- the agency responsible for administering the Medicaid Program in Louisiana.

Disapproval- a determination by the department that a proposal does not meet the criteria of the Facility Need Review Program and that the proposed facility/beds may not participate in Medicaid.

*Emergency Community Home Bed Pool*Ca pool consisting of approved beds which have been transferred from state developmental centers and which are made available for transfer to nonstate-operated community homes in order to address emergency situations on a case-by-case basis.

Enrollment in Medicaid- execution of a provider agreement with respect to reimbursement for services provided to Title XIX eligibles.

Facility Need Review- a review conducted for Nursing Facility (NF) beds (including skilled beds, IC-I and IC-II beds), and ICF-MR beds, to determine whether there is a need for additional beds to enroll and participate in the Medicaid Program.

Group Home-a type of community residential facility which has a capacity of nine to 15 beds.

HCFA- Health Care Financing Administration.

Health Standards Section- the Section in the Bureau of Health Services Financing, Office of the Secretary, which licenses health care facilities, certifies those applying for participation in the Medicaid (Title XIX) and Medicare (Title XVIII) Programs, conducts surveys and inspections, and enrolls Title XIX providers.

*Hospital Service District*Ca political subdivision of the State of Louisiana created or authorized pursuant to R.S. 46:1051 et seq.

*Intermediate Care*C*Level I (IC-I)*- a level of care within a Nursing Facility (NF) which provides basic nursing services under the direction of a physician to persons who require a lesser degree of care than skilled services, but who need care and services beyond the level of room and board. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day.

*Intermediate Care*C*Level II (IC-II)*-a level of care within a Nursing Facility (NF) which provides supervised personal care and health related services, under the direction of a physician, to persons who need nursing supervision in addition to help with personal care needs. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day.

Intermediate Care Facility for the Mentally Retarded (ICF-MR)- a facility which provides mentally retarded

residents with professionally developed individual plans of care, supervision, and therapy, to attain or maintain optimal functioning.

Medicaid Program- the program administered in accordance with Title XIX of the Social Security Act.

Medicaid State Plan- the plan under which the Department of Health and Hospitals administers the Medicaid Program.

Notification- is deemed to be given on the date on which a decision is mailed by the Facility Need Review Program or a hearing officer.

Nursing Facility- an institution which:

a. is primarily engaged in providing to residents:

i. skilled nursing care and related services for residents who require medical or nursing care;

ii. rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

iii. on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities; said institutional facilities are those facilities which are not primarily for the care of mental diseases;

b. has in effect a transfer agreement with one or more hospitals.

Person- an individual or other legal entity.

Program- the Facility Need Review Program.

Review Period- the period of time in which the review is conducted.

Secretary- the secretary of the Department of Health and Hospitals.

Skilled Nursing Care- a level of care within a Nursing Facility (NF) which provides intensive, frequent, and comprehensive nursing care and/or rehabilitation services ordered by and under the direction of a physician. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day. Skilled beds are located in nursing facilities and in "distinct parts" of acute care hospitals. Facility Need Review policies governing skilled beds in nursing facilities apply to Title XIX Skilled beds in hospitals; in order to be enrolled in Title XIX, skilled beds in hospitals must be approved through Facility Need Review. Skilled care is also referred to as "extended care."

C. Department Designation and Duties

1. The department shall be responsible for reviewing proposals for facilities and beds by health care providers seeking to participate in Medicaid; the secretary or his designee shall issue a decision of approval or disapproval.

2. The duties of the department under this program are including, but are not limited to, the following:

a. to determine the applicability of these provisions to all requests for approval to enroll facilities or beds in the Medicaid Program;

b. to review, determine and issue approvals or disapprovals for proposals determined to be subject to these provisions;

c. to adopt and promulgate such rules and regulations as may be necessary to implement the provisions of this program pursuant to the Administrative Procedure Act; and

d. to define the appropriate methodology for the collection of data necessary for the administration of the program.

D. Scope of Coverage. The Facility Need Review Program reviews proposals for increases in the number of beds eligible to participate in Medicaid. The following types of facilities/beds are reviewed:

1. nursing facilities (includes skilled, IC-I and IC-II beds)

2. intermediate care facilities for the mentally retarded

E. Grandfather Provision. An approval shall be deemed to have been granted under this program without review for nursing facilities (NF'S), and ICF-MR facilities and/or beds described below:

1. all valid Section 1122 approved health care facilities/beds;

2. all valid approvals for health care facilities/beds issued under the Medicaid Capital Expenditure Review Program prior to the effective date of this program.

3. all valid approvals for health care facilities issued under the Facility Need Review Program.

4. all nursing facility beds which were enrolled in Medicaid as of January 20, 1991.

F. Revocation of Approvals/Availability of Beds for Title XIX Recipients

1. Nursing facility beds which are added to existing, licensed facilities must be enrolled in the Title XIX Program within one year of the date of approval by the Facility Need Review Program. New nursing facilities which are approved to be constructed must be enrolled in the Title XIX Program within 24 months of the date of the approval. An extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God). Inappropriate zoning is not a basis for extension.

2. Group and community home beds for the mentally retarded must be enrolled in the Title XIX Program within nine months of the date of approval by the Facility Need Review Program. A one-time 90-day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God). Inappropriate zoning is not a basis for an extension.

3. If the beds are not enrolled in the Title XIX program within the time limits specified in F.1 and F.2 of this Section, the approval will automatically expire.

4. When the Office for Citizens with Developmental Disabilities advises that a group or community home bed for the mentally retarded/developmentally disabled which was approved for Title XIX reimbursement to meet a specific disability need identified in a Request for Proposals (RFP) issued by the department, is not being used to meet the need identified in the RFP, based on the facility serving a Medicaid recipient in the bed without prior approval from the Office for Citizens with Developmental Disabilities, approval of the bed shall be revoked.

5. Approvals shall be revoked when a facility's license is revoked, or not renewed, or denied, unless the facility obtains a license within 120 days from the date of such revocation, non-renewal, or denial.

6. Approvals shall be revoked when a facility's provider agreement is terminated unless, within 120 days thereof, the facility enters into a new provider agreement.

7. Beds may not be disenrolled, except as provided under the alternate use policy, under the Emergency Community Home Bed Pool exception, and during the 120-day period to have beds relicensed or recertified. The approval for beds disenrolled, except as indicated, will automatically expire.

8. A nursing facility's approved beds may be relocated only under the following conditions.

a. The approved beds cannot be relocated to a different service area.

b. Subject to the exception provided in Subparagraph c, all of the approved beds must be relocated to a single new location, and the approval of any beds not relocated to that new location shall be revoked.

c. Notwithstanding the requirements of Subparagraph b, a partial relocation of approved beds may be effected if the following conditions are met:

i. the approved beds are in a nursing facility owned by a hospital service district as of the date of adoption of this Rule and at the time of the partial relocation;

ii. the partial relocation meets the requirements of Subparagraph a;

iii. the approved beds are relocated to the site of a currently operational hospital owned by the same or a different hospital service district. If the new location is owned by a different hospital service district, the ownership of the approval of the relocated beds must be transferred to the hospital service district to which the beds are relocated;

iv. no more than 25 percent of the nursing facility's approved beds are relocated.

d. If, within five years after a partial relocation to a hospital site pursuant to Subparagraph c, the hospital located at that site ceases operations, the relocated beds shall revert to the original facility from which they were relocated. This provision shall not apply to relocations which require a transfer of ownership of the approval of the relocated beds.

e. A hospital service district may relocate or transfer the ownership of the approval of approved beds pursuant to Subparagraph c only once.

f. Subparagraphs c, d, and e are not intended to prohibit or restrict the relocation of all of the approved beds in a nursing facility by a hospital service district in accordance with Subparagraphs a and b.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002).

§12503. Determination of Bed Need

A. Community and Group Home Beds for the Mentally Retarded

1. The service area for a proposed or existing facility is designated as the department's Administrative Region in which the facility or proposed facility is or will be located. The department's Administrative Regions, and the parishes which comprise these regions, are as follows:

a. Region I: Jefferson, Orleans, Plaquemines, and St. Bernard;

b. Region II: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana;

c. Region III: Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, and Terrebonne;

d. Region IV: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion;

e. Region V: Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis;

f. Region VI: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn;

g. Region VII: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster;

h. Region VIII: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll; and

i. Region IX: Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.

2. The beds and population of the service area where the facility is located, or is proposed to be located, will be considered in determining need for the facility/beds. Beds which are counted in determining need for community and group homes are approved licensed beds, and approved but not licensed beds, as of the due date for a decision on an application.

3. Data sources to be used include information compiled by the Facility Need Review Program, and the middle population projections recognized by the State Planning Office as official projections. Population

projections to be used are those for the year in which the beds are to be enrolled in Medicaid.

4. In accordance with the department's policy of least restrictive environment, there is no currently identified need for additional facilities with 16 or more beds. Therefore, applications for facilities of 16 or more beds shall not be accepted for review, and applications to increase existing facilities to 16 or more beds shall not be accepted for review.

5. At the present time, the recommended bed-to-population ratio for community and group homes has been achieved. However, special needs and circumstances may arise which the department may consider as indicators of need for additional beds, such as occupancy rates, availability and accessibility of clients in need of placements, patient origin studies, and requests for special types of beds or services.

a. For service areas in which average annual occupancy for the four most recent quarters (as reported in the MR-2) is in excess of 93 percent, the department may review the census data, utilization trends, and other factors described in Subsection A.5 of this Section, to determine if additional beds are needed.

b. If the department determines that there is a need for beds in a parish with average annual occupancy in excess of 93 percent, a Request for Proposals (RFP) will be issued. The RFP will indicate the region in need of beds, the number of beds needed, the date by which the beds are needed to be available to the target population (enrolled in Medicaid), and the factors which the department considers relevant in determining the need for the additional beds. The RFP will specify the MR-2 on which the determination of need is based.

c. The RFP will be issued through the press (AP, UPI, nearest major metropolitan newspaper), and will specify the dates during which the department will accept applications.

d. No applications will be accepted under these provisions unless the department declares a need and issues a Request for Proposals. Applications will be accepted for expansion of existing facilities and/or for the development of new facilities.

e. Applications will be accepted for a period to be specified in the RFP. Once submitted, an application cannot be changed; additional information will not be accepted.

f. The department will review the proposals and independently evaluate and assign points to each of the following 10 items on the application for the quality and adequacy of the response to meet the need of the project:

i. work plan for Medicaid certification;

ii. availability of the site for the proposal;

iii. relationship or cooperative agreements with other health care providers;

iv. accessibility to other health care providers;

v. availability of funds; financial viability;

vi. experience and availability of key personnel;

vii. range of services, organization of services and program design;

viii. methods to achieve community integration;

ix. methods to enhance and assure quality of life; and

x. plan to ensure client rights, maximize client choice and family involvement.

g. A score of 0-20 will be given to the applicant's response to each item using the following guideline.

0 =	inadequate response
5 =	marginal response
10 =	satisfactory response
15 =	above average response; and
20 =	outstanding response

h. If there is a tie for highest score for a specific facility/beds for which the department has requested proposals, a comparative review of the top scoring proposals will be conducted. This comparative review will include prior compliance history. In the case of a tie, the department will make a decision to approve one of the top scoring applications based on comparative review of the proposals.

i. If no proposals are received which adequately respond to the need, the department may opt not to approve an application.

j. At the end of the 90-day review period, each applicant will be notified of the department's decision to approve or disapprove the application. However, the department may extend the evaluation period for up to 60 days. Applicants will be given 30 days from the date of receipt of notification by the department in which to file an appeal (refer to §12505.C, Appeal Procedures).

k. The issuance of the approval of the proposal with the highest number of points shall be suspended during the 30-day period for filing appeals and during the pendency of any administrative appeal. All administrative appeals shall be consolidated for purposes of the hearing.

l. Proposals approved under these provisions are bound to the description in the application with regard to type of beds and/or services proposed as well as to the location as defined in the Request for Proposals made by the department. Approval for Medicaid shall be revoked if these aspects of the proposal are altered. Beds to meet a specific disability need approved through this exception must be used to meet the need identified.

m. Prior approval of all Medicaid recipients for admission to facilities in beds approved to meet a specific disability need identified in a Request for Proposals issued by the department is required from the Office for Citizens with Developmental Disabilities before admission.

6. Exception for beds approved from downsizing large residential ICF-MR facilities (16 or more beds):

a. a facility with 16 or more beds which voluntarily downsizes its enrolled bed capacity in order to establish a

group or community home will be exempt from the bed need criteria. Beds in group and community homes which are approved under this exception are not included in the bed-to-population ratio or occupancy data for group and community homes approved under the Facility Need Review Program;

b. any enrolled beds in the large facility will be disenrolled from the Title XIX Program upon enrollment of the same number of group or community home beds;

c. state-owned facility beds downsized to develop community or group home beds not owned by the state:

i. when the department intends to downsize the enrolled bed capacity of a state-owned facility with 16 or more beds in order to develop one or more group or community home beds not to be owned by the state, a Request for Proposals (RFP) will be issued. The RFP will indicate the parish or region where the beds are to be developed, the number of beds to be developed, and the date by which the beds are to be made available to the target population (enrolled in Medicaid);

ii. the RFP will be issued and beds made available using methods described in Subsection A.5.c through m of this Section;

d. for private facility beds downsized to privately owned group or community homes, these facilities should contact the regional Office for Citizens with Developmental Disabilities, in the region where the proposed community or group home beds will be located. These proposals do not require Facility Need Review approval.

7. Emergency Community Home Bed Pool Exception

a. The Emergency Community Home Bed Pool consists of all Medicaid enrolled beds which have been authorized to be transferred from state developmental centers to nonstate-operated community homes on or before June 30, 2002, in order to address emergency situations on a case-by-case basis.

b. Effective July 1, 2002, the Secretary of the Department may not authorize the transfer of any beds from the Emergency Community Home Bed Pool to a nonstate operated community home unless the bed had been authorized to be transferred to a nonstate operated community home on or before June 30, 2002 and was subsequently transferred from that facility back to the pool pursuant to §12503.7.f.

c. Emergency situations which may be addressed through the use of the Emergency Community Home Bed Pool shall include, but not be limited to, situations in which it is difficult or impossible to find a placement for an individual in an ICF/MR because of one of the following:

i. an inadequate number of available ICF/MR beds in the service area to serve the needs of the mentally retarded/developmentally disabled population in general;

ii. an inadequate number of available ICF/MR beds in the service area to serve the needs of the mentally retarded/developmentally disabled population who also have physical or behavioral disabilities or difficulties;

iii. an inadequate number of available ICF/MR beds in the service area to provide for the transition of individuals from residing in large residential facilities to residing within the community.

d. Any agency or individual who becomes aware of an actual or potential emergency situation should inform the Office for Citizens with Developmental Disabilities (OCDD). The OCDD shall submit to the Facility Need Review Program its recommendations for emergency placement. The recommendations from the OCDD shall include identification of the individual in need of emergency placement, the individual's needs, the service area in which transfer from the Emergency Community Home Bed Pool is requested, and the names of one or more existing community homes that would be appropriate for emergency placement.

e. To be eligible for transfer of one or more beds from the Emergency Community Home Bed Pool, a community home must meet the following requirements, based on documentation provided by the Health Standards Section.

i. The facility must comply with the physical accessibility requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 973, or if it does not comply with those requirements, it must have a written plan to be in compliance within 24 months.

ii. The facility can not have been on a termination track or have had any repeat deficiencies within the last 12 months.

iii. The facility must meet all square footage requirements, *Life Safety Code* requirements and general construction requirements of 42 CFR Subpart D, Conditions of Participation for ICF/MR, as well as Standards for Payment, LAC 50:II.Chapter 103 and Louisiana Licensing Requirements for Intermediate Care Facilities.

iv. The facility must ensure the provision of sufficient staffing and behavior modification plans to meet the needs of current residents and prevent clients residing in the facility from being adversely affected by the emergency admission.

f. The Secretary shall authorize the transfer of the bed to be used at the nonstate-operated community home, and upon the enrollment of the transferred bed at that community home, it shall be permanently transferred to that facility, subject to the following conditions.

i. Once the bed is no longer needed to remedy the emergency situation, the facility shall continue to make it available for subsequent emergency placements, although it may be used temporarily to serve other individuals until it is needed for a new emergency placement.

ii. The facility shall make the bed available for a new emergency placement within 72 hours after receiving a request for such placement from the department as set forth herein. If the facility does not comply with such a request, the secretary may, at his discretion, transfer the bed from the facility back to the Emergency Community Home Bed Pool.

g. Beds which have been placed in the Emergency Community Home Bed Pool shall be exempt from the bed

need criteria and the requirements for requests for proposals which are normally applicable to ICF/MRs.

h. For purposes of the Emergency Community Home Bed Pool exception, the definition of "service area" provided in §12503.A.1 is applicable.

B. Nursing Facilities/Beds

1. Service Area. The service area for proposed or existing nursing facilities/beds is the parish in which the site is located. Exceptions are the parishes of Ascension, Iberville, Plaquemines and St. John, each of which is composed of two separate service areas as divided by the Mississippi River.

2. Nursing facility beds located in "distinct parts" of acute care general hospitals must be approved through Facility Need Review in order to be enrolled in Medicaid.

3. In reviewing the need for beds, all proposed beds shall be considered available as of the projected date of the project. The Facility Need Review Program does not recognize the concept of "phasing-in" beds, whereby an applicant provides two or more opening dates.

4. For reviews in which the bed to population ratio is a factor, the bed inventory which will be used is that which is current on the date on which the complete application is received. The bed to population ratio will be recomputed during the review period when the report is incorrect due to an error by the department.

5. For reviews in which utilization is a factor, the occupancy report which will be used is that which is current on the date on which the complete application is received. The occupancy rate will be recomputed during the review period when the report is incorrect due to an error by the department.

6. In determining occupancy rates of nursing facilities/beds:

a. beds for which occupancy shall be based shall include nursing facility beds (skilled, IC-I and IC- II) which are enrolled in Title XIX;

b. each licensed bed shall be considered as available for utilization for purposes of calculating occupancy;

c. a bed shall be considered in use, regardless of physical occupancy, based on payment for nursing services available or provided to any individual or payer through formal or informal agreement.

7. The beds and population of the service area where the facility is located, or is proposed to be located, will be considered in determining need for the facility/beds. Beds which are counted in determining need for nursing facilities/beds are approved licensed beds, and approved but not licensed beds, as of the due date for decision on an application.

8. Data sources to be used include information compiled by the Facility Need Review Program, and the middle population projections recognized by the State Planning Office as official projections. Population projections to be used are those for the year in which the beds are to be enrolled in Medicaid.

9. In order for additional beds/facilities to be added in a service area, the bed-to-population ratio for nursing facility beds shall not exceed 65 Medicaid approved beds per 1,000 elderly population in a service area, and average annual occupancy for the four most recent quarters (as reported in the LTC-2) shall exceed 95 percent in the service area. Exceptions for areas with high occupancy are described below:

a. a Medicaid enrolled nursing facility which maintains 98 percent average annual occupancy of its enrolled beds for the four most recent quarters (as reported in the LTC-2) may apply for approval for additional beds to be enrolled in the Medicaid Program:

i. in order for an application to be considered, all approved beds in the facility must be enrolled in Title XIX;

ii. in order for a facility to reapply for additional beds, all approved beds must be enrolled in Title XIX for the four most recent quarters, as reported in the LTC-2;

iii. the number of beds for which application may be made shall not exceed 10 beds;

iv. in determining occupancy rates for purposes of this exception, only an adjustment of one additional day after the date of death, for the removal of personal belongings, shall be allowed, if used for that purpose. This adjustment shall not be allowed if nursing services available or provided to another individual are paid for through formal or informal agreement in the same bed for that time period;

v. in determining occupancy rates, more than one nursing facility bed enrolled in Title XIX shall not be considered occupied by the same resident, regardless of payment for nursing services available or provided;

vi. for a Medicaid enrolled nursing facility with high occupancy to apply for additional bed approval, documentation of availability of health manpower for the proposed expansion shall be required;

vii. for a Medicaid enrolled nursing facility with high occupancy to apply for additional bed approval, for the most recent 36 months preceding the date of application, compliance history and quality of care performance of the applicant facility must be void of any of the following sanctions:

(a). appointment of a temporary manager;

(b). termination, non-renewal or cancellation, or initiation of termination or non-renewal of provider agreement;

(c). license revocation or non-renewal.

b. when average annual occupancy for the four most recent quarters (as reported in the LTC-2) exceeds 95 percent in a parish, the department will determine whether additional beds are needed, and if indicated, may issue a Request for Proposals to develop the needed beds:

i. upon issuance of the utilization report the department will identify the parishes with average annual occupancy in excess of 95 percent. The LTC-2 is issued by the department in the fourth month following the end of each calendar quarter;

ii. for each parish in which average annual occupancy is in excess of 95 percent, the department, in order to determine if additional beds are needed, may review the census data, utilization trends, and other factors such as special needs in an area, information received from other health care providers and other knowledgeable sources in the area, waiting lists in existing facilities, requests from the community, patient origin studies, appropriateness of placements in an area, remoteness of an area, occupancy rates in adjoining and/or adjacent parishes, availability of alternatives, reasonableness of distance to facilities, distribution of beds within a service area or geographical area, and such other factors as the department may deem relevant. The number of beds which can be added shall not exceed 15 percent of the existing approved beds in the parish, or 120 beds, whichever is less. The department will strive to assure that occupancy in existing facilities in the area will not decline below 85 percent as a result of the additional beds;

iii. if the department determines that there is in fact a need for beds in a parish with average annual occupancy in excess of 95 percent, a Request for Proposals (RFP) will be issued. The RFP will indicate the parish and/or area in need of beds, the number of beds needed, the date by which the beds are needed to be available to the target population (enrolled in Medicaid), and the factors which the department considers relevant in determining need for the additional beds. The RFP will specify the LTC-2 on which the determination of need is based;

iv. the RFP will be issued through the press (AP, UPI, nearest metropolitan area newspaper), and will specify the dates during which the department will accept applications. Also, nursing facilities in the service area and adjoining parishes will be notified of the RFP;

v. no applications will be accepted under these provisions unless the department declares a need and issues a Request for Proposals. Applications will be accepted for expansions of existing facilities and/or for the development of new facilities;

vi. applications will be accepted for a 30-day period, to be specified in the RFP. Once submitted, an application cannot be changed; additional information will not be accepted;

vii. the department will review the proposals and independently evaluate and assign points (out of a possible 120) to the applications, as follows:

0-20 points:	Availability of beds to the Title XIX population. note: work plan for Medicaid certification, and availability of site for the proposal;
0-20 points:	Appropriateness of location, or proposed location. note: accessibility to target population, relationship or cooperative agreements with other health care providers, and distance to other health care providers;
0-20 points:	Availability of funds; financial viability;
0-20 points:	Responsiveness to groups with special needs (e.g. AIDS patients, ventilator assisted patients; technology dependent patients);
0-20 points:	Experience and availability of key personnel (e. g., director of nursing, administrator, medical director);
0-20 points:	Distribution of beds/facilities within the service area. Geographic distribution of existing beds and population density will be taken into account.

viii. a score of 0-20 will be given to the applicant's response to each item using the following guideline:

0 =	inadequate response
5 =	marginal response
10 =	satisfactory response
15 =	above average response; and
20 =	outstanding response

ix. if there is a tie for highest score for a specific facility/beds for which the department has requested proposals, a comparative review of the top scoring proposals will be conducted. In the case of a tie, the department will make a decision to approve one of the top scoring applications based on comparative review of the proposals;

x. if no proposals are received which adequately respond to the need, the department may opt not to approve an application;

xi. at the end of the 60-day review period, each applicant will be notified of the department's decision to approve or disapprove the application. However, the department may extend the evaluation period for up to 30 days. Applicants will be given 30 days from the date of receipt of notification by the department in which to file an appeal (refer to §12505.C, Appeal Procedures);

xii. the issuance of the approval of the application with the highest number of points shall be suspended during the 30-day period for filing appeals and during the pendency of any administrative appeal. All administrative appeals shall be consolidated for purposes of the hearing;

xiii. proposals submitted under these provisions are bound to the description in the application with regard to the type of beds and/or services proposed as well as to the site/location as defined in the request made by the department. Approval for Medicaid certification shall be revoked if these aspects of the proposal are altered.

10. Alternate Use of Licensed Approved Title XIX Beds. In a service area in which average annual occupancy is lower than 93 percent, a nursing home may elect to temporarily convert a number of Title XIX beds to an alternate use (e.g., adult day care). The beds may be converted for alternate use until such time as the average annual occupancy in the service area exceeds 93 percent (based on the LTC-2 report) and the facility is notified of the same. The facility shall then either re-enroll the beds as nursing home beds within one year of receipt of notice from the department that the average annual occupancy in the service area exceeds 93 percent. The approval for beds not re-enrolled by that time will be expired.

a. A facility is prohibited from adding beds when alternately using beds.

b. All approved beds must be enrolled as nursing home beds in Title XIX for the four most recent quarters, as reported in the department's occupancy report, in order for additional beds to be approved.

c. A total conversion of all beds is prohibited.

11. Additional Beds for Replacement Facility. A nursing facility that has had all approved beds enrolled for the four most recent quarters (as reported in the LTC-2), and is structurally older than 25 years, may apply for approval for additional beds to be enrolled in the Medicaid Program in a replacement facility. The number of beds for which application may be made shall not exceed 20 beds, except that a facility may be approved for sufficient beds to bring the total approved beds in the replacement facility to 80, and except that a facility shall not be approved for beds that would exceed 130 total approved beds in the replacement facility. Sufficient documentation must be submitted to demonstrate to the department's satisfaction that the facility is structurally older than 25 years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002).

§12505. Application Procedures

A. General

1. Application shall be made to the department on forms provided for that purpose and shall contain such information as the department may require. Applications shall be submitted on 8 1/2" by 11" paper, and shall be accompanied by a non-refundable fee of $10 per bed. An original and three copies of the application shall be submitted.

2. The applicant representative specified on the application will be the only person to whom the Facility Need Review Program sends written notification in matters relative to the status of the application during the review process. If the applicant representative (or his address) changes at any time during the review process, the applicant shall notify the Facility Need Review Program in writing.

3. Applicants may request application forms in writing or by telephone from the Facility Need Review Program. The Facility Need Review Program will provide the applicant with application forms, inventories, utilization data, and other materials relevant to the type of application.

B. Review Process

1. The review period will be no more than 60 days, except as otherwise outlined in §12503.A.5.j and §12503.B.6.b.xi. The review period begins on the first day after the date of receipt of the application, or, in the case of issuance of an RFP, on the first day after the period specified in the RFP.

2. A longer review period will be permitted only when requested by the Facility Need Review Program. A maximum of 30 days will be allowed for an extension, except as otherwise outlined in §12503.A.5.j. An applicant may not request an extension of the review period, but may withdraw (in writing) an application at any time prior to the notification of the decision by the Facility Need Review Program. The application fee is non-refundable.

3. The Facility Need Review Program shall review the application within the specified time limits and provide written notification of the decision to the applicant representative. Notification of disapproval shall be sent by certified mail to the applicant representative, with reasons for disapproval specified. If notification is not sent by the sixtieth day, except as outlined in §12503.A.5.j and B.6.b.x, the application is automatically denied.

C. Appeal Procedures

1. Upon refusal of the department to grant approval, only the applicant shall have the right to an administrative appeal. A written request for such an appeal (by registered mail) must be received by the secretary of the Department of Health and Hospitals within 30 days after the notification of disapproval is received by the applicant. A fee of $500 shall accompany a request for an appeal.

2. Hearings shall be conducted by a hearing officer designated by the governor, provided that no person who has taken part in any prior consideration of, or action upon the application, may conduct such hearings. However, a hearing officer who presided over a hearing and remanded the matter to the department may hear a subsequent appeal of the same application if the department again disapproves the application.

3. The hearing shall commence within 30 days after receipt of the written request for the hearing. Requests by the department or the applicant for extensions of time within which to commence a hearing may be granted at the discretion of the hearing officer, provided that if the hearing is not concluded within 180 days from the date of receipt by the applicant of notification of disapproval, the decision of the department will be considered upheld.

4. The hearing officer shall have the power to administer oaths and affirmations, regulate the course of the hearings, set the time and place for continued hearings, fix the time for filing briefs and other documents, and direct the parties to appear and confer to consider the simplification of the issues. The hearing shall be open to the public.

5. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. Evidence which possesses probative value commonly accepted by reasonably prudent men in the conduct of their affairs may be admitted and given probative effect. The rules of privilege recognized by law shall be given effect. Objections to evidentiary offers may be made and shall be noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form.

6. All evidence, including records and documents in the possession of DHH of which it desires to avail itself, shall be offered and made part of the records, and all such documentary evidence may be received in the form of copies or excerpts, or by incorporation by reference. In case of incorporation by reference, the materials so incorporated

shall be available for examination by the parties before being received in evidence. Notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within DHH's specialized knowledge. Parties shall be notified either before or during the hearing or by reference in preliminary reports or otherwise of the material notices, including any staff memoranda or data, and they shall be afforded an opportunity to contest the material so noticed.

7. The hearing officer shall have the power to sign and issue subpoenas, or to direct the department to do so, in order to require attendance and the testimony by witnesses and to require the productions of books, papers and other documentary evidence. The applicant is required to notify the hearing officer in writing at least 10 days in advance of the hearing of those witnesses whom he wishes to be subpoenaed. No subpoena shall be issued until the party (other than the department) who wishes to subpoena a witness first deposits with the hearing officer a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled pursuant to R.S. 13:3661 and R.S. 13:3671. DHH may request issuance of subpoenas without depositing said sum of money. The witness fee may be waived if the person is an employee of DHH. When any person summoned under this section neglects or refuses to obey such summons, or to produce books, papers, records, or other data, or to give testimony, as required, DHH may apply to the judge of the district court for the district within which the person so summoned resides or is found, for an attachment against him as for a contempt. It shall be the duty of the judge to hear the application, and, if satisfactory proof is made, to issue an attachment, directed to some proper officer, for the arrest of such person, and upon his being brought before him, to proceed to a hearing of the case; and upon such hearing, the judge may issue such order as he shall deem proper, not inconsistent with the law for the punishment of contempt, to enforce obedience to the requirements of the summons and to punish such person for this default or disobedience.

8. The department or any party to the proceedings may take the deposition of witnesses, within or without the state, in the same manner as provided by law for the taking of depositions in civil actions in courts of record. Depositions so taken shall be admissible in the review proceeding at issue. The admission of such depositions may be objected to at the time of hearing and may be received in evidence or excluded from the evidence by the hearing officer in accordance with the rules of evidence provided in Subsection C of this Section.

9. The applicant, the department, and any other agency which reviewed the application, and other interested parties, including members of the public and representatives of consumers of health services, shall be permitted to give testimony and present arguments at the hearing without formally intervening. Such testimony and arguments shall be presented after the testimony of the applicant and DHH has been presented, or, at the discretion of the hearing officer, at any other convenient time. When such testimony is presented, all parties may cross-examine the witness.

10. A record of the hearing proceeding shall be maintained. Copies of such record together with copies of all documents received in evidence shall be available to the parties, provided that any party who requests copies of such material may be required to bear the costs thereof.

11. The hearing officer shall notify all parties, in writing or on the record, of the day on which the hearing will conclude and of any changes thereto; provided, a hearing must be concluded in accordance with the time requirements specified in Paragraph C.3 of this Section. As soon as practicable, but not more than 45 days after the conclusion of a hearing, the hearing officer shall send to the applicant, the department, and to any interested parties who participated in the hearing, his written decision and the reasons for the decision. Such decisions shall be publicized by the department through local newspapers and public information channels. After rendering his decision, the hearing officer shall transmit the record of the hearing to the department.

12. An applicant who fails to have the disapproval reversed shall forfeit his filing fee.

13. Judicial review of the decision of the hearing officer shall be in accordance with the provisions of R.S. 49:964 provided, however, that only an applicant aggrieved by the decision of the hearing officer shall have the right to judicial review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:812 (August 1995).